

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12897 63-049567  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED JAN 6 1964

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>10 days</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bethesda Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>3026 Arlington Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Michael</b> Last <b>Jakubiak</b>		4. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>63</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/11/95</b>
9. AGE (last birthday) <b>68</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager - Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Assn.</b>	
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Martin Jakubiak</b>		13b. MOTHER'S MAIDEN NAME <b>Leokadya Rychek</b>	
14. NAME OF HUSBAND OR WIFE <b>Martha Jakubiak</b>		Address <b>3026</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>Yes WW I</b>		17. INFORMANT <b>Mrs. Martha Jakubiak</b> <b>Arlington</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic cancer</b> of colon to Liver & Lungs <b>153.8</b> Interval between ONSET AND DEATH <b>7 months</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>June - 1953</b> to <b>Dec 25 / 63</b> and last saw him alive on <b>12/25/63</b> Death occurred at <b>6:00</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>malesher B. Gaudel W.</b>		22b. ADDRESS <b>4660 Maywood</b>	
22c. DATE SIGNED <b>12/24/63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>12/28.63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Drehmann-Harral 1905 Union</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 27 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Loan Smith. M.D.</b>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR TYPEWRITER RIBBON

VS 300  
Rev. 4/59

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DATE AMENDED

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Dr. Malcolm B. Bawell  
4660 Maryland  
Fo. 1-6074

Hrs. 2-3:30 Thurs.  
9-12 2-4 Fri.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Warren A. Carver*

Licensed Embalmer No.

*3534*

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.